Chapter 5
Integrating Traditional and Modern Medical Practices: Perspectives from the History of Science and Medicine

James J. Bono

Introduction

> Seventeenth-century [European medical] travelers to China marveled at the astonishing prowess of local healers, and especially at their exquisite feel for the pulse. The uncanny accuracy of their diagnoses bordered on the incredible [1].

As historian of medicine Shigehisa Kuriyama tellingly reminds us, we have always lived in a world replete with multiple, independent, and yet effective, medical systems. Not surprisingly, then, there remains even today much to be learned of value to practitioners and their patients from efforts to integrate traditional and modern medical practices and health perspectives. Over the course of centuries, distinct medical systems have come into contact with one another to varying degrees and with different results. The movement of peoples over time and space—through, for example, trade routes, warfare, the spread of the world's major religions, or the exigencies of sociopolitical, economic, or environmental change leading to forced or voluntary migrations—has continually shaped and reshaped practices, beliefs, goals, expectations, institutions, and the very roles signified by categories such as "patients" and "practitioners" that we associate with the presence and operation of established medical traditions. Few medical systems are "islands" unto themselves; interaction, change, appropriation, and a host of (positive, negative, or neutral) "symbiotic" relations mark historic and emergent exchanges among the world's multiple medical systems and traditions.

Whether working globally or locally, health professionals are continually faced with increasingly complex and variable sets of beliefs, practices, and frameworks among patients they encounter in their own and in different communities and countries. For modern allopathic health and medical practitioners, it is fundamentally

J. J. Bono (✉)
University at Buffalo, State University of New York (SUNY), Buffalo, NY, USA
e-mail: hischaos@buffalo.edu

important to recognize this fact, and to resist uncomprehending and dismissive attitudes with respect to the beliefs, practices, and medical systems of "others." The challenge of recognizing and responding appropriately to differences and different medical systems is not new: most importantly, those who persist may reap the reward of an expanded repertoire of techniques and modes of understanding vital to addressing the needs of all patients.

Whether or not we recognize it, the fact is that patients bring to their interactions with modern medicine a variety of beliefs, practices, and frameworks regarding bodies, health, illness, and healing. Depending upon the histories and circumstances of specific individuals from diverse communities, "traditional" medical systems and practices may play a significant role in shaping individual or collective beliefs, practices, and frameworks. Typically, allopathic professionals know little about traditional medical systems: about how those systems might affect patients with whom they interact professionally, and what to do should they become aware of individual patients' adherence to such systems. While it is neither practical nor necessary for such professionals to become experts in a range of traditional medical systems, nonetheless, misalignments between patient and practitioner beliefs, practices, and systems typically result in one or more problems: miscommunication and misunderstanding; recommendations that are at odds with patient understandings, beliefs, and/or values; mistrust leading possibly to anger and rejection of modern medicine; patient "non-compliance" coupled with deteriorating medical conditions and/or physician frustration, to cite some prominent consequences.

As an issue confronting global health care and equity, the effects of multiple, co-existing medical systems are complex and variable. In high-income, industrialized countries, indigenous systems of traditional medicine still exist. In addition, patterns of immigration—including the resettlement of refugees from across the globe—have led to multiple, pluralized medical cultures co-existing, often silently, barely noticed by modern medical practitioners. Thus, two differential sets of challenges must be addressed: First, in countries with relatively robust "traditional" medical systems including large numbers of adherents among practitioners and patients. Second, in countries like the USA, where a great variety of indigenous and transplanted traditional medical systems exist—often unrecognized—as part of the cultural inheritance of multiple and diverse patient populations. Complicating this picture is the fact that, with different patient populations, knowledge of such systems and adherence to their practices, beliefs, and values vary tremendously from community to community, from family to family, from one generation to the next, and, of course, from one individual to another (Fig. 5.1).

Global Health and Modern Medicine: One Among Many

While a widespread presence, in many areas of the world modern allopathic medicine remains a far from dominant actor, especially among non-elites and extra-urban populations. Where advocates of modern medicine and global health equity seek to

Fig. 5.1 Traditional Chinese Medicine being sold at market. (Source: Xi'an, China—Traditional Medicine Market, Joel, 2007, unmodified, CC BY-ND 2.0. Image: www.flickr.com/photos/jminnick/522693227. License: https://creativecommons.org/licenses/by-nd/2.0/)

improve health outcomes in such settings, the challenges are often daunting. Take, for example, women's and neonatal health. As one study soberly notes, "Maternal and neonatal health has received increasing attention as mortality rates refuse to fall in the poorest populations. More than two-thirds of all newborn deaths occur in just 10 countries, the same countries in which more than 60% of maternal deaths occur." [2] While overall such statistics have improved in recent years, nonetheless, it remains advisable that in addressing and ameliorating such stark conditions, as this same study asserts, we "develop interventions that meet the health needs of disadvantaged women and newborn infants," which, in turn, "requires knowledge of the context in which poorest families make decisions on their health." [2] More explicitly still, a key obstacle to understanding such decision-making contexts and formulating "appropriate interventions" is precisely the "lack of understanding of local beliefs and practices (and the reasons for them)." [2]

Tackling such problems and developing effective strategies and interventions, then, must begin with understanding contexts, practices, and meanings of health and health-related care among specific local populations in question. An important tool for achieving such goals is undertaking a "qualitative study of care practices and beliefs during pregnancy, birth, and postpartum." [2] Importantly, the goal of such studies represents something far more robust than simply developing a general "cultural competence" among advocates and providers of modern Western medicine. Rather than focusing upon some generalized and abstract notion of "culture," such

studies aim instead to sort-out and understand the local contexts, practices, and beliefs among individuals and families. That is to say, rather than acting on pre-formed assumptions based upon stereotypes of cultural beliefs and social norms, the key to such qualitative studies is to unearth how specific individuals and communities translate generalized beliefs and norms into localized beliefs, practices, and actions. Acquiring such knowledge and understanding always entails listening, observing, and nuanced interrogation. Rather than racing toward conclusions based upon partial (and presumptive) cultural understanding, the appropriate stance should be one of "hesitation"—of slowing-down in order to understand and before acting [3–5]. We shall return to this issue later in this chapter.

To achieve such goals in a nuanced and rigorous manner, the article cited provides a sample of some exemplary approaches. For one, beyond the views and practices embraced by centralized, and typically modernized, government health care systems, the authors describe and advocate the work of numerous researchers in multiple countries with at-risk populations in establishing "community level" partnerships with village representatives, "local women's groups," and such key actors as "female community health volunteers" and local practitioners, including those considered to be a "traditional healer." [2] As the authors rightfully suggest, such a "participatory approach was also attractive because of its tolerance of diversity. Contextual differences within the study area might affect how an intervention is received. Participatory development practitioners believe that to transform society, local stakeholders should be active participants in problem identification, planning, implementation and evaluation." [2]

In practice, this meant attending carefully to the roles played by a variety of actors—including those noted above—in seeking care for pregnant women and neonates. Traditional healers, of course, bring to those seeking care selective aspects of indigenous medical systems: selective because in each instance the knowledge and practices brought to bear in a given case varies with the level of sophistication achieved by the practitioner in question. In rural Nepal, the study not surprisingly reports that in many cases a "healer who was a friend or relative was called first." In cases where "the condition worsened," those responsible for making decisions would then turn to a person with a reputation as a more sophisticated and knowledgeable healer, who might well hail from a more distant village [2]. Even prior to seeking such professional advice, pregnant women and mothers of newborns would typically depend upon a hierarchy of decision-makers within their family: especially elders (e.g., mothers and mothers-in-law) whose views were informed by experience, by expertise in family remedies, and by their own localized variant of shared traditional knowledge of pregnancy, childbirth and neonatal health, and beliefs, concepts of health, illness, and the body and its vulnerabilities. As the authors note, the existence of multiple actors, of a hierarchy of decision-makers, and the circulation of beliefs and practices—in part traditional and shared; in part localized and variable—point to the "social nature of decision making during illness" in rural Nepal [2].

Of course, at any given moment and in any specific case, any number of cultural beliefs and practices may also come into play, all susceptible to individual and

localized variations: concerns over "pollution" or "uncleanliness"; "embarrassment or shame"; the perceived need to protect vulnerable individuals against others (strangers; "evil spirits") [2]. All of these factors form the background to, and precede chronologically, any attempt to introduce modern allopathic medical interventions. Indeed, the authors argue convincingly that any attempt to suggest the introduction of such interventions must take into consideration such backgrounds. Moreover, the implication of their study is that such a methodology can and should apply to other different, but analogous settings in a variety of countries and continents where local customs, beliefs, decision-making hierarchies, and traditional medical systems form the setting within which other actors seek to introduce modern medical interventions.

Key to the results of their study and attendant recommendations is operationalizing the "participatory approach" that they deem vital to successful integration of traditional and modern medical approaches. Such operationalizing begins with seeking appropriate, context-dependent, "answers to four questions: (1) Who should implement the intervention? (2) What should the intervention address? (3) Who should be the major stakeholders in the intervention? and (4) what should the intervention be?" [2]. In discussing these questions in the context of women's and neonatal health in rural Nepal, let us cite a few major points raised by the authors: points that can, and we believe should, be generalized to many other analogous situations faced by global health advocates across the world. First, the authors note the important point that "an intervention should tackle delays in care seeking by addressing the familial context." This seemingly unremarkable suggestion is easily ignored or forgotten in practice, with consequences that can be disastrous. Any number of cultural beliefs and attitudes—not just traditional medical beliefs—can prove to be barriers in seeking interventions beyond those provided by traditional medical practices. Of course, one structural component in care-seeking behavior, and therefore in seeking access to modern allopathic medicine, in many societies across the globe (including urban and industrialized settings) can be the status of women within families and within societies. With respect to their rural Nepalese families, the authors suggest that "Women's low status in the home may affect their ability to act on existing or learned knowledge: it would take great courage and personal strength for her to challenge tradition." The authors' own intervention, then, recognizes and responds to such constraints by attempting to address "women's empowerment" in culturally and socially nuanced ways. More specifically, they observe that "An intervention that directly challenges tradition … might be inappropriate." This is precisely where "understanding of local contexts" as noted above must be combined with "good facilitation skills"—with careful, culturally and structurally competent, forms of communication and intervention strategies [2]. The formation of "groups of women" who collectively identified and discussed problems facing pregnant women and neonates and decided how to respond to possible new interventions from outside traditional beliefs and practices proved decisive and effective in enabling "a community-based, community-responsive intervention to be initiated" [2]. What results ensued? "In intervention areas," the authors in conclusion report, "large reductions in neonatal mortality and maternal mortality were

Fig. 5.2 Acupuncture at Taeyoungdang Oriental Medicine, a component of traditional Chinese medicine. (Source: Dongdaemun-gu, 2010; CC BY 2.0, SellyourSeoul. Image: www.flickr.com/photos/sellyourseoul/4273475678. License: https://creativecommons.org/licenses/by/2.0/)

observed, and there was increased care seeking for health problems. Care behaviors … also improved, and groups continued to meet regularly." The key seems to be "building an intervention that is acceptable" [2].

Other studies echo and support many of the approaches and conclusions discussed above. Understanding the contexts of care—the hierarchy of care-givers, including traditional healers—and the dynamics of decision-making within families and localized communities; attention to obstacles affecting care-seeking behaviors and receptivity to modern allopathic medical systems, especially those rooted in cultural and religious beliefs and practices; developing models based on listening, on learning how to communicate effectively with diverse individuals and groups espousing a variety of traditional beliefs and practices; empowering individuals—especially women and new or prospective mothers—by fostering participatory approaches to understand and change complex health-related behaviors through the organization of community-based discussion, support, and planning groups: some combination of these approaches seem to represent a growing wave of new and effective intervention strategies among recent field-based researchers. Indeed, such approaches offer the promise of significant, positive results not only in the case of Nepal highlighted earlier, but more broadly in India, Pakistan, South Asia, Africa, and Central America [6–13] (Fig. 5.2).

Strangers in Strange New Lands? The Ubiquity of Modern Medicine within Pluralistic Urban-Industrial Landscapes

With declining child mortality and rising life expectancy, modern medicine has achieved global recognition in most highly industrialized and urban settings, signaled not least by the sheer presence of massive medical research and clinical

complexes; extensive institutional, governmental, and governance structures; and, as a consequence, vast economic resources coupled with privileged social and cultural authority. Taken together such highly visible complexes (hospitals, public and private research complexes) and behind the scenes institutions not readily visible to most ordinary citizens (e.g., government agencies, professional biomedical organizations) testify to the power, prestige, and centrality of modern medicine. Yet, in the very shadows of such complexes and institutions, modern urban-industrial societies harbor diverse, plural populations embracing congeries of distinctive beliefs, practices, values, and stories regarding the body, health, illness, and well-being. Highly technologized practitioners of modern medicine must, again, continually acknowledge and take account of the presence of patients with divergent views and competing systems of care if they are to achieve the goal of global health equity at home as well as within distant lands.

In some urban-industrialized settings, the presence of competing systems is a palpably visible and historically acknowledged fact. Within such settings (for example, in Korea and Taiwan), institutions, health-care practitioners, and patients frequently encounter differences and conflicts requiring negotiation, which may or may not result in accommodation [14–17]. Less visible and often ignored are the continued presence of pluralized, "traditional" beliefs—alternative views of the body, health, and disease; and health-care practices—in urban-industrialized settings where the dominance of modern Western medicine appears virtually hegemonic, most notably in the USA. While both sorts of settings present their own challenges, the second in particular proves especially difficult due to the relative invisibility of alternatives to mainstream modern medicalized understandings of health and illness. In what follows, we shall focus attention on the latter.

Nonetheless, it is worth noting that both kinds of settings offer the prospect of addressing the encounter between "modern" and "traditional" medical systems in two separate, though not mutually exclusive, ways: (1) a chiefly medical response that seeks first and foremost to assess the strengths and weaknesses of mainstream and alternative medical systems, either in a spirit of contestation, or one of emergent cooperation embracing an ideal of "integrative medicine" and (2) a patient-centered approach whose goal is to facilitate the best possible outcomes as mutually and cooperatively defined through careful listening, questioning, and narrative construction of the history and meaning of illness in ways that are capable of describing culturally responsive, and personally resonant (yet possible and pragmatic) trajectories for *this* individual patient and *this* specific illness.

While in some circles there is widespread interest in possibilities for integrating modern and traditional medical systems, such possibilities remain controversial, if not contentious, for much of mainstream Western academic medicine and its many practitioners. Comparative assessment of alternative medicine itself can be controversial; certainly, no consensus has yet emerged, nor have we yet witnessed robust and ubiquitous commitments to such assessments. That said, the fact that the very term, "Integrative Medicine" (referring to actively pursuing pragmatic models for combining Western allopathic with "traditional" medical practices and therapies) is now well established—that there are centers or units designated for the study of

integrative medicine or medical therapies at such medical schools as the University of Arizona and Harvard University—points to a growing insistence that plural medical approaches to health, illness, diagnosis, and therapy are desirable, of value to patients, and, indeed, necessary to promote health and well-being. On the one hand, as Dr. Andrew Weil notes, while openness to such efforts in the USA and China may be on the upswing, strong resistance remains, with the very notion of what counts as evidence clearly itself a matter of dispute [18]. Indeed, methodologies (such as Koch's postulates from the late nineteenth century) for establishing causative agents in disease, or contemporary insistence on the need for evidence-based medicine, play precisely into a logic in which only those phenomena—and therapeutic results—for which we have established tools and technologies capable of uncovering underlying "mechanisms" or revealing statistically persuasive relationships can be considered real. What such tried and tested approaches to knowledge-production rule out-of-bounds are exactly alternative forms of knowledge and "expertise" that champion the utility of phenomena, practices, and therapies that are not, or cannot be, studied in such ways.

In addition, Weil cites the case of "Latin America," where "traditional herbal medicine and other forms of folk medicine are widely used." Yet, he notes that, "these are completely separated from conventional medicine. There is no communication, no integration … in these Latin American countries, academic medicine and conventional medicine are very rigid, very closed to any other ways of thinking" [18]. On the other hand, in much of Europe and Australia efforts are under way to document, describe, criticize, and refine models for integrating traditional and modern medicine, especially in primary care settings—to understand and redefine their relationship as symbiotic [19].

While integrative medicine remains open to multiple systems of traditional medicine, for Weil and many others, attention not surprisingly focuses largely upon traditional Chinese medicine [20, 21]. As a robust system with a long and documented history, Chinese medicine presents modern Western medicine with the testimony of longstanding practices providing experiential evidence of diagnostic and therapeutic successes. Those open to integrative approaches oftentimes see such practices and successes as complementary to modern Western medicine with the weaknesses of one system (e.g., pain management) complemented by the strengths of the other. Such complementarity should not be surprising and seems well worth serious attention by researchers and clinicians. As historian of medicine Shigehisa Kuriyama (cited earlier) has effectively argued, Chinese and Western medicine, respectively, employ differential techniques of seeing, feeling, observing, and describing the body in health and in illness that serve to capture diverse if not divergent aspects—different empirical regularities, irregularities, and interrelationships—of organs and bodies than the other system (Fig. 5.3).

While efforts to assess medically the encounter between traditional and modern medical systems and consequently arrive at consensus regarding their possible integration in theory and in practice remain ongoing and unresolved, if unquestionably important, there should be no question at all that modern Western medical practice must attend to the system of beliefs, conceptions of the body, health, and illness, and

Fig. 5.3 Cupping with bamboo, a component of traditional Chinese medicine. (Source: Randy Adams, 2012, CC BY-ND 2.0. Image: www.flickr.com/photos/7830239@N06/2445098397. License: https://creativecommons.org/licenses/by-nd/2.0/)

the health-care practices associated with traditional medicine. For such beliefs, concepts, and practices continue to circulate among diverse groups within the USA and elsewhere [22]. Despite various degrees of assimilation, we remain a heterogeneous nation comprised of the descendants of indigenous peoples, historic-era settlers, and waves of subsequent immigrants and refugees some more and some less removed from folk and traditional modalities of health beliefs, values, and practices. Whether deeply ingrained within patterns of traditional medical behaviors and beliefs rooted in a shared experience of a still cohesive community, or unselfconsciously and selectively adopting and adapting distantly remembered patterns inherited from one's forebears, each one of us as individuals and patients brings our own distinctive, if unarticulated, understandings of health, illness, and what constitutes appropriate care to our encounters with physicians and health-care providers. Such individualized views and practices shape our decisions and subsequent behaviors. Let us, then, conclude with discussion of how a patient-centered practice of modern medicine ought to respond to such challenges.

Perspectives from the Health and Medical Humanities

Increasingly, the practice of medicine has come to be informed by perspectives championed by the health and medical humanities, with the latter's emphasis upon eliciting the experience and meaning of illness serving as the basis for the mutual negotiation of care between patients and physicians especially in cases of chronic and serious illness [23–25]. Negotiating care builds on the capacity to listen and communicate effectively with patients in order to explore and appreciate the goals of individual patients, the contexts shaping those goals, and the nature and sources of any barriers that stand in the way of effective communication and negotiation of care. Not surprisingly, the meaning and experience of illness vary from patient to patient, affected by a variety of factors, especially the patient's beliefs and understanding, their past history, their social contexts and support networks, and the existence and perception of a host of vulnerabilities. Key to understanding patients and negotiating care, then, is eliciting and learning how to address such factors appropriately. Where patients' beliefs about the body, health, and illness—including the meaning and experience of illness—vary dramatically from that of "mainstream" physicians and patients familiar to them (much more likely to be the case with patients raised within different, traditional medical systems and cultures of care) cultivating such techniques for negotiating care become all the more critical.

Advocates of "Narrative Medicine" appreciate the power of patients' own implicit stories—the still emergent narrative trajectories of their lives together with challenges, threats, and possibilities posed by their illnesses [26–29]. Such emergent life-stories shape patients' experience of illness and work to construct the meanings they have for them. As a result, cultivating the ability to discern patterns in patients' experience of and response to illness, coming to recognize the sources of concern, suffering, fear, hope—in short, the roots of the imagined meanings of their illnesses—prove invaluable to the narratively competent health-care provider. Often, negotiating care becomes a matter of working together with a patient to facilitate the adaptive re-imagining of their life-stories in the face of serious and chronic diseases that threaten to alter their trajectories.

Many illnesses pose such threats to patients. Yet, time and again, we can be surprised both by what individual patients do or do not perceive as a threat, and why. The very existence, nature, and meaning of a threat are not themselves predictable. Two patients faced with the same diagnosis of cancer with similar prognoses are as likely as not to react in remarkably different ways. One patient faced with a chronic condition that limits mobility—or some other non-life threatening, yet consequential, function—may suffer terribly from such an emergent loss, where another may prove immune to suffering, adapting, instead, to changed circumstances. As no less a figure as Dr. Eric J. Cassell has noted, the reasons why patients suffer are multiple, rooted in their most fundamental sense of identity, and require that we talk with patients if we wish to understand and help [30, 31]. Here, then, is where histories and contexts matter. Here, in turn, is where the need arises to cultivate (and critically interrogate) what many have called "cultural competence" among health-care providers.

But, what is cultural competence and what does it demand of the practitioner? We start with a commonplace: individual patients are members of communities, frequently members of multiple communities—an ethnic group or nationality; a religious community; a vocational or professional community; etc. As members of one or more community, each patient has access to entire repertoires of beliefs, concepts, practices, and values. Among these "cultural" elements we may include those associate with the body, health, illness, and well-being: as noted above, the degree to which they are shaped by inherited traditional medical systems depends on many factors. In any case, we have long recognized specific patterns of belief and practices regarding health and illness that have come to be attributed, for example, to members of specific immigrant communities and ethnicities [32–34]. Cultural competence certainly involves the ability to recognize the existence, operation, and effect of such cultural factors—including effects of traditional medical beliefs and practices—*together with* cultivating strategies for assessing their impact on individual patients, while responding appropriately to them in ways that exemplify "narrative competence": how they "fit" into patterns and life-stories unique to *this* patient who stands before us. Failing to do so could result in misunderstandings, misdiagnoses, and mismanagement of patients and their families in ways that may prove harmful, or even tragic.

However, we must also recognize what cultural competence does not, or should not, include. Most certainly, it does not demand that health-care providers be professional anthropologists: that they be experts in one or more cultures, nor that they be experts in one or more traditional medical systems. A truly critical cultural competence should instead hold up as an ideal the ability to recognize when a patient—as an individual, and not as a mere stereotypical member of an ethnicity or "culture"—may adhere to beliefs or practices that diverge from "mainstream" modern medicine, and to assess when such commitments are consequential with respect to negotiating care and creating the conditions for the best possible outcome for the specific patient in question. Of course, the conditions affecting patient care and outcomes go beyond those critically apprehended and addressed by cultural competence alone. Often, structural factors—whether related to cultural factors such as those facing recent immigrant and refugee populations, or not—play a large role in patient access to care, to health-seeking behaviors, and to equity in health-care more generally. Poverty, housing, access to food, class and racial barriers, and a host of other structural factors must not be ignored: cultural competence is inadequate if not conjoined with structural competence [35, 36].

Finally, pursuing the goal of cultural competence should not and must not generate unintended consequences that serve to undermine effective care and genuinely dialogic negotiation between patient and practitioner. As the renowned medical anthropologist and physician, Arthur Kleinman (and co-author, Peter Benson) note:

> One major problem with the idea of cultural competency is that it suggests culture can be reduced to a technical skill for which clinicians can be trained to develop expertise. The problem stems from how culture is defined in medicine, which contrasts strikingly with its current use in anthropology … Culture is often made synonymous with ethnicity, nationality, and language. For example, patients of a certain ethnicity—such as, the "Mexican

patient"—are assumed to have a core set of beliefs about illness owing to fixed ethnic traits. Cultural competency becomes a series of "do's and don'ts" that define how to treat a patient of a given ethnic background. The idea of isolated societies with shared cultural meanings would be rejected by anthropologists, today, since it leads to dangerous stereotyping—such as, "Chinese believe this," "Japanese believe that," and so on—as if entire societies or ethnic groups could be described by these single slogans [37].

As noted at the very beginning of this chapter, few medical systems [if, indeed, any!] are "islands" unto themselves. Medical systems are inherently historical, dynamically changing, and symbiotic: when, by contrast, we treat them as monoliths—as silently, hegemonically, and invariably imposed upon individuals without regard for the multiplicity of possible meanings, interpretations, and practices that shape individuals' understandings of medical knowledge and how they respond to medical advice—we do so at our, and our patients', peril. As always, we must ask, rather than assume; we must listen, rather than pronounce; we must learn to formulate questions appropriately, and attend carefully to the nuances and individuality of what we hear from our patients (Fig. 5.4).
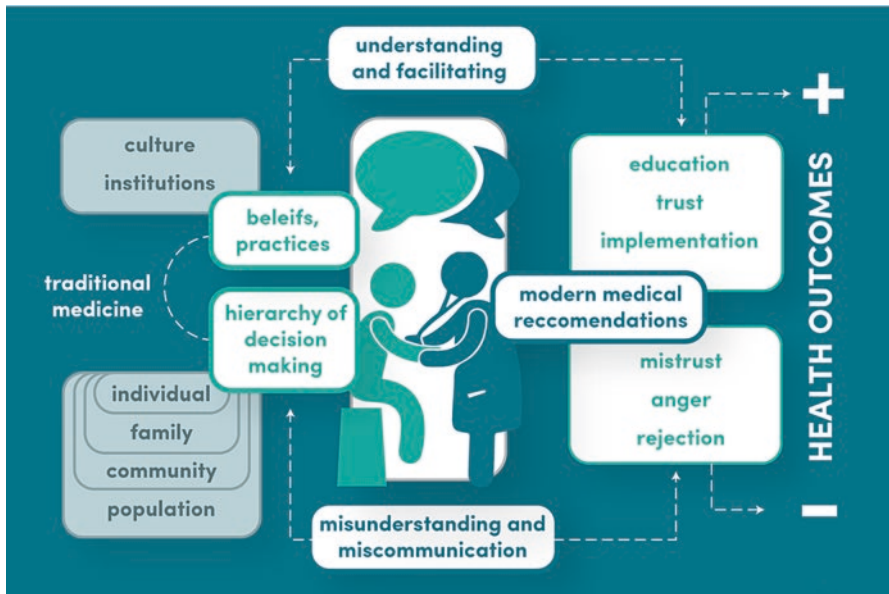

Fig. 5.4 Integration of traditional medicine and modern medicine. (Source: Nicole C. Little and James Bono)

Perspectives from the Field: Cultural Competency or Ethnography?

It is of course legitimate and highly desirable for clinicians to be sensitive to cultural difference, and to attempt to provide care that deals with cultural issues from an anthropological perspective. We believe that the optimal way to do this is to train clinicians in ethnography. "Ethnography" is the technical term used in anthropology for its core methodology… What sets this apart from other methods of social research is the importance placed on understanding the native's point of view. The ethnographer practices an intensive and imaginative empathy for the experience of the natives—appreciating and humanly engaging with their foreignness, and understanding their religion, moral values, and everyday practices.

Ethnography is different than cultural competency. It eschews the 'trait list approach' that understands culture as a set of already-known factors, such as 'Chinese eat pork, Jews don't.' (Millions of Chinese are vegetarians or are Muslims who do not eat pork; some Jews, including the corresponding author of this paper [i.e., Kleinman], love pork.) Ethnography emphasizes engagement with others and with the practices that people undertake in their local worlds. It also emphasizes the ambivalence that many people feel as a result of being between worlds (for example, persons who identify as both African-Americans and Irish, Jewish and Christian, American and French) in a way that cultural competency does not. And ethnography eschews the technical mastery that the term 'competency' suggests. Anthropologists and clinicians share a common belief—i.e., the primacy of experience. The clinician, as an anthropologist of sorts, can empathize with the lived experience of the patient's illness, and try to understand the illness as the patient understands, feels, perceives, and responds to it [37].

Kleinman's Template of Exemplary Questions: Eliciting the Patient's Understanding of Illness

What do you call this problem?
What do you believe is the cause of this problem?
What course do you expect it to take? How serious is it?
What do you think this problem does inside your body?
How does it affect your body and your mind?
What do you most fear about this condition?
What do you most fear about the treatment? [37].

References

1. Kuriyama S. The expressiveness of the body and the divergence of Greek and Chinese medicine. New York: Zone Books; 1999. p. 21.
2. Morrison J, Osrin D, Shrestha B, et al. How did formative research inform the development of a women's group intervention in rural Nepal? J Perinatol. 2008;28:S14–22.
3. Stengers I. The cosmopolitical proposal. In: Latour B, Weibel P, editors. Making things public: atmospheres of democracy. Cambridge: MIT Press; 2005. p. 994–1003.

4. Stengers I. Cosmopolitics I. Minneapolis: University of Minnesota Press; 2010.

5. Stengers I. Cosmopolitics II. Minneapolis: University of Minnesota Press; 2011.

6. Neonatal Mortality Formative Research Working Group. Developing community-based intervention strategies to save newborn lives: lessons learned from formative research in five countries. J Perinatol. 2008;28:S2–8.

7. Syed U, Khadka N, Kahn A, Wall S. Care seeking practices in South Asia: using formative research to design program interventions to save newborn lives. J Perinatol. 2008;28:S9–S13.

8. Iyengar SD, Iyengar K, Martines JC, et al. Childbirth practices in rural Rajasthan, India: implications for neonatal health and survival. J Perinatol. 2008;28:S23–30.

9. Mohan P, Iyengar SD, Agarwal K, et al. Care-seeking practices in rural Rajasthan: barriers and facilitating factors. J Perinatol. 2008;28:S31–7.

10. Darmstadt GL, Kumar V, Yadav R, et al. Community perceptions of birth weight in rural Uttar Pradesh, India: implications for care of low-birth-weight infants. J Perinatol. 2008;28:S53–60.

11. Awasthi S, Srivastava NM, Pant S. Symptom-specific care-seeking behavior for sick neonates among urban poor in Lucknow, Northern India. J Perinatol. 2008;28:S69–75.

12. Hill Z, Manu A, Tawiah-Agyemang C, et al. How did formative research inform the development of a home-based neonatal care intervention in rural Ghana? J Perinatol. 2008;28:S38–45.

13. Schooley J, Mundt C, Wagner P, et al. Factors influencing health care-seeking behaviours among Mayan women in Guatemala. Midwifery. 2009;25:411–21.

14. Cho MO. Health care seeking behavior of Korean women with lymphedema. Nurs Health Sci. 2004;6:149–59.

15. Lee MS, Shin B-C, Choi T-Y, Kim J-I. Randomized clinical trials on eastern-western integrative medicine for health care in Korean Literature: a systematic review. Chin J Integr Med. 2011;17(1):48–51.

16. Hung J-Y, Chiou C-J, Chang H-Y. Relationships between medical beliefs of superiority of Chinese or western medicine, medical behaviours and glycaemic control in diabetic outpatients in Taiwan. Health Soc Care Community. 2012;20(1):80–6.

17. Willsky G, Bussmann RW, Ganoza-Yupanqui ML, Malca-Garcia G, Castro I, Sharon D. Utilizing local practices: integrating traditional medicine and the Peruvian Public Health System in Northern Peru. In: Smith K, Ram P, editors. Transforming global health: interdisciplinary challenges, perspectives, and strategies. Cham: Springer International Publishing AG; 2019.

18. Weil A. The state of the integrative medicine in the U.S. and Western World. Chinese Journal of Integrated Medicine. 2011;17(1):6–10, p. 8, p. 10.

19. Templeman K, Robinson A. Integrative medical models in contemporary primary health care. Complement Ther Med. 2011;19:84–92.

20. Eisenberg D. Reflections on the past and future of integrative medicine from a lifelong student of the integration of Chinese and western medicine. Chin J IntegrMed. 2011;17(1):3–5.

21. Robinson N. Integrative medicine—traditional Chinese medicine, a model? Chin J Integr Med. 2011;17(1):21–5.

22. Barnes P, Powell-Griner E, McFann K, Nahin R. Complementary and Alternative Medicine Use among Adults: United States, 2002. Advance Data Report #343; 2004. p. 1–19. https://nccih.nih.gov/ [National Center for Complementary and Integrative Health (NIH): search under "Complementary and Alternative Medicine Use among Adults"].

23. Jones T, Wear D, Friedman LD, editors. Health humanities reader. New Brunswick: Rutgers University Press; 2014.

24. Cassell EJ. The place of the humanities in medicine. In: Ethics and the life sciences. Hastings-on-Hudson: Institute of Society; 1984.

25. Cassell EJ. Talking with patients. Vol. 1, the theory of doctor-patient communication. Vol. 2, clinical technique. Cambridge: MIT Press; 1985.

26. Kleinman A. The illness narratives: suffering, healing, and the human condition. New York: Basic Books; 1988.

27. Hunter KM. Doctors' stories: the narrative structure of medical knowledge. Princeton: Princeton University Press; 1991.

28. Charon R. Narrative medicine: honoring the stories of illness. New York: Oxford University Press; 2006.

29. Schleifer R, Vannatta JB. The Chief concern of medicine: the integration of the medical humanities and narrative knowledge into medical practice. Ann Arbor: University of Michigan Press; 2013.
30. Cassell EJ. The nature of suffering and the goals of medicine. N Engl J Med. 1982;306(11):639–45.
31. Cassell EJ. The nature of suffering and the goals of medicine. New York: Oxford University Press; 1991.
32. Harwood A. The hot-cold theory of disease: implications for treatment of Puerto-Rican patients. J Am Med Assoc. 1971;216:1153–8.
33. Hatcher E, Whittemore R. Hispanic adults' beliefs about type 2 diabetes: clinical implications. J Am Acad Nurse Pract. 2007;19:536–45.
34. Kang Y, Crogan NL. Social and cultural construction of urinary incontinence among Korean American elderly women. Geriatr Nurs. 2008;29(2):105–11.
35. Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. Soc Sci Med. 2014;103:126–33.
36. Judelsohn A, Orom H, Kim I, et al. Planning the city of good (and New) NEIGHBOURS: Refugees' experiences of the food environment in Buffalo, New York. Built Environ. 2017;43(3):426–40.
37. Kleinman A, Benson P. Anthropology in the clinic: the problem of cultural competency and how to fix it. PLoS Med. 2006;3(10):e294. https://doi.org/10.1371/journal.pmed.0030294.